CLAY COUNTY HOSPITAL

FLORA, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED FEBRUARY 29, 2008

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT WORKSHEET S
CERTIFICATION AND SETTLEMENT SUMMARY PARTS I & II

INTERMEDIARY USE ONLY: [ ] AUDITED [ ] DESK REVIEWED DATE RECEIVED _____ INTERMEDIARY NO. _____ [ ] INITIAL [ ] FINAL [ ] RE-OPENING [ ] MCR CODE

PART I - CERTIFICATION

CHECK APPLICABLE BOX: XX ELECTRONICALLY FILED COST REPORT __ MANUALLY SUBMITTED COST REPORT DATE: _07/10/2008 TIME: _17:07____

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY CLAY COUNTY HOSPITAL (14-1351) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 03/01/2007 AND ENDING 02/29/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 07/10/2008 17:07
dLFX3T0C2gkT:zWuaVIzUVWBjtAq20
uymmi0Mtle7nwLCjFp6p.hAV95nKpw
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(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			PART A	PART B		
		1	2	3	4	
1	HOSPITAL		315900	213644		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		6445			3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	OUTPATIENT REHABILITATION PROVIDER					8
9	RURAL HEALTH CLINIC I			108917		9
9.01	RURAL HEALTH CLINIC II					9.01
100	TOTAL		322345	322561		100

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

STREET: 911 STACY BURK DRIVE — P.O.BOX: — 1
CITY: FLORA — STATE: IL — ZIP CODE: 62839-0280 — COUNTY: CLAY — 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	PROVIDER NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
2	HOSPITAL	CLAY COUNTY HOSPITAL	14-1351	12/21/2005	N	O	O	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	CLAY COUNTY SWING BED	14-Z351	12/21/2005	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC	CLAY COUNTY MEDICAL CLINIC	14-3458	11/29/2005	N	O	N	14
14.01	HOSP-BASED RHC II	LOUISVILLE MEDICAL CLINIC	14-3487	12/18/2006	N	O	N	14.01
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 03/01/2007 TO: 02/29/2008		17
		1	2	
18	TYPE OF CONTROL	9		18

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1		19
20	SUBPROVIDER I			20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106?			21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.			21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	Y	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2		21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2		21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO.	NO		21.06
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	NO		22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW	NO		23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE(mm/dd/yyyy)			23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy)			23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy)			23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy)			23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION DATE			23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CTR, ENTER THE CERT. DATE (mm/dd/yyyy)			23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERT. DATE (mm/dd/yyyy)			23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2			24

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

	INFORMATION				
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO			25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO			25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO			25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO			25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO			25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)				25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)				25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:				26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:				26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	01/25/1985		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				28.02
	A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)				
28.03	STAFFING	0.00	N		28.03
28.04	RECRUITMENT	0.00	N		28.04
28.05	RETENTION OF EMPLOYEES	0.00	N		28.05
28.06	TRAINING	0.00	N		28.06
28.07	OTHER (SPECIFY)				28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO			29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES			30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO			30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO			30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO			30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO			30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO			31

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 (CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO	32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO	33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO	34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO	35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

		V 1	XVIII 2	XIX 3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				37.01

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES	38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO	38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	YES	38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO	38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO	38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	NO	40
40.01	NAME: FI/CONTRACTOR'S NAME: FI/CONTRACTOR'S NUMBER:		40.01
40.02	STREET: P.O.BOX:		40.02
40.03	CITY: STATE: ZIP CODE:		40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES	41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES	42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO	43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO	44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO	45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.		46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

		PART A 1	PART B 2	OUTPATIENT ASC 3	OUTPATIENT RADIOLOGY 4	OUTPATIENT DIAGNOSTIC 5	
47	HOSPITAL	N	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N				49
50	HOME HEALTH AGENCY	N	N				50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	NO	52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.	NO	52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		53
53.01	MDH PERIOD: BEGINNING: ENDING:		53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		54
	PREMIUMS: 250138 PAID LOSSES: AND/OR SELF INSURANCE:		
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	YES	54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

		DATE 0	Y/N 1	LIMIT 2	Y/N 3	FEES 4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO				58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				59
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)						60.01

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH PATIENT HOURS	I/P DAYS / O/P VISITS / TRIPS				
					TITLE V	TITLE XVIII	LTCH NONCOVERED DAYS	TITLE XIX	OBS. BEDS ADMITTED
		1	2	2.01	3	4	4.01	5	5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	22	8052	112128.0		3443		455		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					559				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	22	8052	112128.0		4002		455		5
6	INTENSIVE CARE UNIT									6
7	CORONARY CARE UNIT									7
8	BURN INTENSIVE CARE UNIT									8
9	SURGICAL INTENSIVE CARE UNIT									9
10	OTHER SPECIAL CARE (SPECIFY)									10
11	NURSERY									11
12	TOTAL HOSPITAL	22	8052	112128.0		4002		455		12
13	RPCH VISITS									13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY									15
16	NURSING FACILITY									16
17	OTHER LONG TERM CARE									17
18	HOME HEALTH AGENCY									18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC I					5395				24
24.01	RHC II									24.01
25	TOTAL	22								25
26	OBSERVATION BED DAYS							51	4	26
27	AMBULANCE TRIPS					777				27
28	EMPLOYEE DISCOUNT DAYS									28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	-----I/P DAYS / O/P VISITS / TRIPS---- OBS. BEDS NOT ADMITTED 5.02	TOTAL ALL PATIENTS 6	OBS. BEDS ADMITTED 6.01	OBS. BEDS NOT ADMITTED 6.02	---INTERNS & RES FTES---- TOTAL 7	LESS I&R REPL PHYS 8	LESS I&R REPL NON-ANES 8	NET 9	--FULL TIME EQUIV-- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		4672									1
2	HMO XIX											2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		559									3
4	HOSPITAL ADULTS & PEDS - SWING BED NF											4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		5231									5
6	INTENSIVE CARE UNIT											6
7	CORONARY CARE UNIT											7
8	BURN INTENSIVE CARE UNIT											8
9	SURGICAL INTENSIVE CARE UNIT											9
10	OTHER SPECIAL CARE (SPECIFY)											10
11	NURSERY											11
12	TOTAL HOSPITAL		5231							155.60		12
13	RPCH VISITS											13
14	SUBPROVIDER I											14
15	SKILLED NURSING FACILITY											15
16	NURSING FACILITY											16
17	OTHER LONG TERM CARE											17
18	HOME HEALTH AGENCY											18
20	ASC (DISTINCT PART)											20
21	HOSPICE (DISTINCT PART)											21
23	O/P REHAB PROVIDER											23
24	RHC I		19848							3.99		24
24.01	RHC II											24.01
25	TOTAL									159.59		25
26	OBSERVATION BED DAYS	47	246	20	226							26
27	AMBULANCE TRIPS											27
28	EMPLOYEE DISCOUNT DAYS											28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		965	160	1192	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		965	160	1192	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
24.01	RHC II					24.01
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

RHC I WORKSHEET S-8
COMPONENT NO: 14-3458

PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
PROVIDER STATISTICAL DATA

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 929 STACY BURK DRIVE		1
1.01	CITY: FLORA STATE: IL ZIP CODE: 62839 COUNTY: CLAY		1.01
2	DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN		2

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD 1	DATE 2	
3	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)		/ /	3
4	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /	4
5	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)		/ /	5
6	APPALACHIAN REGIONAL COMMISSION		/ /	6
7	LOOK-ALIKES		/ /	7
8	OTHER		/ /	8

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NO.	
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	ALDEN JALLORINA, MD	G57720	9
9.01		HEIDELENE DE LA ROSA, MD		9.01
9.02		GALEN F LUEKING, MD	C41343	9.02
9.03		JENNIFER MANEJA, MD	154401	9.03
9.04		FAIYAZ AHMED	D14758	9.04

		PHYSICIAN NAME	HOURS	
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	ALDEN JALLORINA, MD	40.00	10
10.01		GALEN F LUEKING, MD	40.00	10.01
10.02		HEIDI DE LA ROSA, MD	40.00	10.02
10.03		JENNIFER MANEJA, MD	40.00	10.03

11	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)	NO	11

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
12	CLINIC			800	1700	800	1700	800	1700	800	1700	800	1700			12

(ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS OF OPERATION)
LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

13	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	NO		13
14	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.	YES	2	14
15	PROVIDER NAME: CLAY COUNTY HOSPITAL CLIN	PROVIDER NUMBER: 14-3458		15
15.01	LOUISVILLE MEDICAL CLINIC	14-3487		15.01

		V	XVIII	XIX	
16	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS.	NO			16
17	HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS.	NO			17

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI-FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXP FOR ALLOCATION 7	
		GENERAL SERVICE COST CENTERS								
3	0300	NEW CAP REL COSTS-BLDG & FIXT		1025646	1025646	-13478	1012168	-344001	668167	3
3.01	0301	NEW CAP RHC REL COSTS-BLDG & FI		-6795	-6795	132924	126129		126129	3.01
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		656969	656969	-119446	537523		537523	4
5	0500	EMPLOYEE BENEFITS	82186	1860629	1942815		1942815	-18878	1923937	5
6	0600	ADMINISTRATIVE & GENERAL	599257	981475	1580732		1580732	-109785	1470947	6
8	0800	OPERATION OF PLANT	133853	375534	509387		509387		509387	8
8.01	0801	RHC UTILITY EXPENSE		18561	18561		18561		18561	8.01
9	0900	LAUNDRY & LINEN SERVICE		72440	72440		72440		72440	9
10	1000	HOUSEKEEPING	169561	40053	209614		209614		209614	10
11	1100	DIETARY	157899	130569	288468		288468	-76785	211683	11
12	1200	CAFETERIA								12
14	1400	NURSING ADMINISTRATION	189858	9839	199697		199697		199697	14
15	1500	CENTRAL SERVICES & SUPPLY	21935	-3126	18809		18809		18809	15
16	1600	PHARMACY	137398	-752	136646		136646		136646	16
17	1700	MEDICAL RECORDS & LIBRARY	237588	35343	272931		272931	-3252	269679	17
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	890804	46745	937549		937549		937549	25
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	378462	114470	492932	11322	504254		504254	37
40	4000	ANESTHESIOLOGY	45	268774	268819	-11322	257497	-257497		40
41	4100	RADIOLOGY-DIAGNOSTIC	328237	479399	807636		807636		807636	41
44	4400	LABORATORY	376101	628887	1004988		1004988		1004988	44
49	4900	RESPIRATORY THERAPY	200721	23081	223802	-39705	184097	-2392	181705	49
50	5000	PHYSICAL THERAPY	418298	16170	434468		434468	-475	433993	50
53	5300	ELECTROCARDIOLOGY	23130	5319	28449	29779	58228	-23130	35098	53
54	5400	ELECTROENCEPHALOGRAPHY		54786	54786	9926	64712	-53600	11112	54
55	5500	MEDICAL SUPPLIES CHARGED TO PAT		294254	294254		294254	-787	293467	55
56	5600	DRUGS CHARGED TO PATIENTS		367522	367522		367522		367522	56
59	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVI		426053	426053		426053		426053	59
		OUTPATIENT SERVICE COST CENTERS								
61	6100	EMERGENCY	341820	1106351	1448171		1448171	-637177	810994	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RHC	901552	624811	1526363		1526363	-28510	1497853	63.50
		OTHER REIMBURSABLE COST CENTERS								
65	6500	AMBULANCE SERVICES	340533	43586	384119		384119		384119	65
71	7100	HOME HEALTH AGENCY								71
		SPECIAL PURPOSE COST CENTERS								
95		SUBTOTALS	5929238	9696593	15625831		15625831	-1556269	14069562	95
		NONREIMBURSABLE COST CENTERS								
	9600	GIFT, FLOWER, COFFEE SHOP & CAN								96
	9800	PHYSICIANS' PRIVATE OFFICES	15606	7560	23166		23166		23166	98
101		TOTAL	5944844	9704153	15648997		15648997	-1556269	14092728	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5	
1	DEPRICIATION	A	NEW CAP RHC REL COSTS-BLDG &	3.01		125416	1
2	RESPIRATORY THERAPY	B	ELECTROCARDIOLOGY	53	29779		2
3		B	ELECTROENCEPHALOGRAPHY	54	9926		3
4	INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	3.01		7508	4
5		C	NEW CAP REL COSTS-MVBLE EQUIP	4		5970	5
6	OPERATING ROOM	D	OPERATING ROOM	37		11322	6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				39705	150216	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	DEPRICIATION	A	NEW CAP REL COSTS-MVBLE EQUIP	4		125416	9	1
2	RESPIRATORY THERAPY	B	RESPIRATORY THERAPY	49	39705			2
3		B						3
4	INSURANCE EXPENSE	C	NEW CAP REL COSTS-BLDG & FIXT	3		13478	12	4
5		C					12	5
6	OPERATING ROOM	D	ANESTHESIOLOGY	40		11322		6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36	TOTAL RECLASSIFICATIONS				39705	150216		36

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES								3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT								6
7	SUBTOTAL								7
8	RECONCILING ITEMS								8
9	TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	132111					132111		1
2	LAND IMPROVEMENTS	221790	5063		5063		226853		2
3	BUILDINGS AND FIXTURES	10996836	588003		588003		11584839		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	5263435	281059		281059	7278	5537216		5
6	MOVABLE EQUIPMENT								6
7	SUBTOTAL	16614172	874125		874125	7278	17481019		7
8	RECONCILING ITEMS								8
9	TOTAL	16614172	874125		874125	7278	17481019		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	COMPUTATION OF RATIOS: GROSS ASSETS (1)	CAPITALIZED LEASES (2)	GROSS ASSETS FOR RATIO (3)	RATIO (4)	ALLOCATION OF OTHER CAPITAL: INSURANCE (5)	TAXES (6)	OTHER CAPITAL-RELATED COSTS (7)	TOTAL (8)	
1	OLD CAP REL COSTS-BLDG & FIXT				.000000					1
2	OLD CAP REL COSTS-MVBLE EQUIP				.000000					2
3	NEW CAP REL COSTS-BLDG & FIXT	9546517		9546517	.550266					3
3.01	NEW CAP RHC REL COSTS-BLDG & FI	2265175		2265175	.130566					3.01
4	NEW CAP REL COSTS-MVBLE EQUIP	5537216		5537216	.319168					4
5	TOTAL	17348908		17348908	1.000000					5

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (12)	TAXES (13)	OTHER CAPITAL-RELATED COSTS (14)	TOTAL (15)	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	628010		13657	26500			668167	3
3.01	NEW CAP RHC REL COSTS-BLDG & FIX	125416	18144		7508	-24939		126129	3.01
4	NEW CAP REL COSTS-MVBLE EQUIP	382592	148961		5970			537523	4
5	TOTAL	1136018	167105	13657	39978	-24939		1331819	5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (12)	TAXES (13)	OTHER CAPITAL-RELATED COSTS (14)	TOTAL (15)	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	628010		357658	39978			1025646	3
3.01	NEW CAP RHC REL COSTS-BLDG & FIX		18144			-24939		-6795	3.01
4	NEW CAP REL COSTS-MVBLE EQUIP	508008	148961					656969	4
	TOTAL	1136018	167105	357658	39978	-24939		1675820	5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-NEW BLDGS & FIXTURES	B	-344001	NEW CAP REL COSTS-BLDG & FIXT	3	11	3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS						6
7	REFUNDS AND REBATES OF EXPENSES						7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-2600	ADMINISTRATIVE & GENERAL	6		8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-3037	ADMINISTRATIVE & GENERAL	6		9
10	TELEVISION AND RADIO SERVICE						10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-744809				12
13	SALE OF SCRAP, WASTE, ETC.						13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1					14
15	LAUNDRY AND LINEN SERVICE						15
16	CAFETERIA - EMPLOYEES AND GUESTS	B	-76785	DIETARY	11		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-787	MEDICAL SUPPLIES CHARGED TO PAT	55		18
19	SALE OF DRUGS TO OTHER THAN PATIENTS						19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3252	MEDICAL RECORDS & LIBRARY	17		20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22	VENDING MACHINES						22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES						23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49		25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50		26
27	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71		27
28	UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89		28
29	DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		29
30	DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		30
31	DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		31
32	DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		32
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20		33
34	PHYSICIANS' ASSISTANT						34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4					35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4					36
37	EKG PHYSICIAN EMPLOYEE BENEFITS	A	-7559	EMPLOYEE BENEFITS	5		37
38	MISCELLANEOUS REVENUE	B	-28557	ADMINISTRATIVE & GENERAL	6		38
39	PUBLIC RELATIONS	A	-68681	ADMINISTRATIVE & GENERAL	6		39
40	LOBBYING EXPENSE	A	-6910	ADMINISTRATIVE & GENERAL	6		40
41	CRNA EXPENSE	A	-257497	ANESTHESIOLOGY	40		41
42	EMPLOYEE BENEFITS LAB TESTS	A	-2233	EMPLOYEE BENEFITS	5		42
43							43
44	PHYSICIAN CLINIC EXPENSE	A	-6378	EMPLOYEE BENEFITS	5		44
45	PHYSICIAN RECRUITMENT	A	-2708	EMPLOYEE BENEFITS	5		45
46	PHYSICIAN RECRUITMENT	A	-475	PHYSICAL THERAPY	50		46
47							47
48							48
49							49
50	TOTAL		-1556269				50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. [illegible]TS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF [illegible]E OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ-USTMENTS	WKST A-7 REF	
1	2	3	4	5	6	7	
1							1
2							2
3							3
4							4
5	TOTALS						5

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

		-------- RELATED ORGANIZATION(S) AND/OR HOME OFFICE ----------					
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS		
1	2	3	4	5	6		
1							1
2							2
3							3
4							4
5							5

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERATION INCL FRINGES 3	PROFESSIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	PERCENT OF UNADJUSTED RCE LIMIT 9
1	44	LABORATORY		24637		24637				
2	63.50	RHC	AGGREGATE	28510	28510					
3	53	ELECTROCARDIOLOGY	AGGREGATE	23130	23130					
4	61	EMERGENCY	AGGREGATE	1074497	637177	437320				
5	54	ELECTROENCEPHALOGRAPHY	AGGREGATE	53600	53600					
6	49	RESPIRATORY THERAPY	AGGREGATE	2392	2392					
101		TOTAL		1206766	744809	461957				

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18
1	44	LABORATORY								
2	63.50	RHC	AGGREGATE							28510
3	53	ELECTROCARDIOLOGY	AGGREGATE							23130
4	61	EMERGENCY	AGGREGATE							637177
5	54	ELECTROENCEPHALOGRAPHY	AGGREGATE							53600
6	49	RESPIRATORY THERAPY	AGGREGATE							2392
101		TOTAL								744809

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW RHC BUILDING FIXTURES 3.01	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT	668167	668167							3
3.01	NEW CAP RHC REL COSTS-BLDG & FI	126129		126129						3.01
4	NEW CAP REL COSTS-MVBLE EQUIP	537523			537523					4
5	EMPLOYEE BENEFITS	1923937			363	1924300				5
6	ADMINISTRATIVE & GENERAL	1470947	294141		45345	198353	2008786	2008786		6
8	OPERATION OF PLANT	509387	5047		9530	44305	568269	94467	662736	8
8.01	RHC UTILITY EXPENSE	18561					18561	3086		8.01
9	LAUNDRY & LINEN SERVICE	72440			179		72619	12072		9
10	HOUSEKEEPING	209614	2769		998	56124	269505	44801	4973	10
11	DIETARY	211683	11768		10714	52264	286429	47615	21137	11
12	CAFETERIA		3776				3776	628	6782	12
14	NURSING ADMINISTRATION	199697	5639		1844	62843	270023	44888	10128	14
15	CENTRAL SERVICES & SUPPLY	18809	5488		1865	7260	33422	5556	9856	15
16	PHARMACY	136646	3058		960	45478	186142	30944	5493	16
17	MEDICAL RECORDS & LIBRARY	269679	41421		12563	78641	402304	66877	74398	17
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	937549	79709		30476	294856	1342590	223187	143170	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	504254	51188		80868	125285	761595	126605	91941	37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC	807636	37809		203696	108646	1157787	192466	67910	41
44	LABORATORY	1004988	12020		47241	124489	1188738	197611	21589	44
49	RESPIRATORY THERAPY	181705	4229		7087	41017	234038	38906	7596	49
50	PHYSICAL THERAPY	433993		17020	41	138456	589510	97998		50
53	ELECTROCARDIOLOGY	35098	4229		8395	19713	67435	11210	7596	53
54	ELECTROENCEPHALOGRAPHY	11112	4216		1715	6571	23614	3925	7573	54
55	MEDICAL SUPPLIES CHARGED TO PAT	293467					293467	48785		55
56	DRUGS CHARGED TO PATIENTS	367522					367522	61095		56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	426053	32498		597		459148	76327	58370	59
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	810994	34247		10581	113142	968964	161077	61513	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	1497853		99903	27751	288975	1914482	318253		63.50
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES	384119	14915		33101	112716	544851	90574	26789	65
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	14069562	648167	116923	535910	1919134	14033577	1998953	626814	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		3386				3386	563	6081	96
98	PHYSICIANS' PRIVATE OFFICES	23166	16614	9206	1613	5166	55765	9270	29841	98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	14092728	668167	126129	537523	1924300	14092728	2008786	662736	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		8.01	9	10	11	12	14	15	16	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
3.01	NEW CAP RHC REL COSTS-BLDG & FI									3.01
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
8	OPERATION OF PLANT									8
8.01	RHC UTILITY EXPENSE	21647								8.01
9	LAUNDRY & LINEN SERVICE		84691							9
10	HOUSEKEEPING			319279						10
11	DIETARY		1438	7895	364514					11
12	CAFETERIA			2532	243731	257449				12
14	NURSING ADMINISTRATION					6958	331997			14
15	CENTRAL SERVICES & SUPPLY		1800	3692		2319	4376	61021		15
16	PHARMACY			2057		4639	8964	74	238313	16
17	MEDICAL RECORDS & LIBRARY			9143		18555				17
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		41856	57301	120783	60302	113562	1251		25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		10826	34374		16236	32408	16399		37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC		7731	25389		18555	33687	3345		41
44	LABORATORY			8070		23194	41543	28004		44
49	RESPIRATORY THERAPY			2831		11597	21198	570		49
50	PHYSICAL THERAPY	2921	3678	14154		18555		927		50
53	ELECTROCARDIOLOGY		977	2831				19		53
54	ELECTROENCEPHALOGRAPHY			2831				5		54
55	MEDICAL SUPPLIES CHARGED TO PAT							7024		55
56	DRUGS CHARGED TO PATIENTS								238313	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI			21802						59
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		12443	22998		18555	33409	1796		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	17146	2150	70294		32471		1469		63.50
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES		1792	10004		23194	42850	136		65
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	20067	84691	298198	364514	255130	331997	61019	238313	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN			2268						96
98	PHYSICIANS' PRIVATE OFFICES	1580		18813		2319		2		98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	21647	84691	319279	364514	257449	331997	61021	238313	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		17	25	26	27	
	GENERAL SERVICE COST CENTERS					
3	NEW CAP REL COSTS-BLDG & FIXT					3
3.01	NEW CAP RHC REL COSTS-BLDG & FI					3.01
4	NEW CAP REL COSTS-MVBLE EQUIP					4
5	EMPLOYEE BENEFITS					5
6	ADMINISTRATIVE & GENERAL					6
8	OPERATION OF PLANT					8
8.01	RHC UTILITY EXPENSE					8.01
9	LAUNDRY & LINEN SERVICE					9
10	HOUSEKEEPING					10
11	DIETARY					11
12	CAFETERIA					12
14	NURSING ADMINISTRATION					14
15	CENTRAL SERVICES & SUPPLY					15
16	PHARMACY					16
17	MEDICAL RECORDS & LIBRARY	571277				17
	INPATIENT ROUTINE SERV COST CENTERS					
25	ADULTS & PEDIATRICS	127733	2231735	2231735		25
	ANCILLARY SERVICE COST CENTERS					
37	OPERATING ROOM	26927	1117311	1117311		37
40	ANESTHESIOLOGY					40
41	RADIOLOGY-DIAGNOSTIC	248907	1755777	1755777		41
44	LABORATORY		1508749	1508749		44
49	RESPIRATORY THERAPY		316736	316736		49
50	PHYSICAL THERAPY		727743	727743		50
53	ELECTROCARDIOLOGY		90068	90068		53
54	ELECTROENCEPHALOGRAPHY		37948	37948		54
55	MEDICAL SUPPLIES CHARGED TO PAT		349276	349276		55
56	DRUGS CHARGED TO PATIENTS		666930	666930		56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI		615647	615647		59
	OUTPATIENT SERVICE COST CENTERS					
61	EMERGENCY	127112	1407867	1407867		61
62	OBSERVATION BEDS (NON-DISTINCT					62
63.50	RHC		2356265	2356265		63.50
	OTHER REIMBURSABLE COST CENTERS					
65	AMBULANCE SERVICES		740190	740190		65
71	HOME HEALTH AGENCY					71
	SPECIAL PURPOSE COST CENTERS					
9	SUBTOTALS	530679	13922242	13922242		95
	NONREIMBURSABLE COST CENTERS					
96	GIFT, FLOWER, COFFEE SHOP & CAN		12298	12298		96
98	PHYSICIANS' PRIVATE OFFICES	40598	158188	158188		98
101	CROSS FOOT ADJUSTMENTS					101
102	NEGATIVE COST CENTER					102
103	TOTAL	571277	14092728	14092728		103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW RHC BUILDING FIXTURES 3.01	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	EMPLOYEE BENEFITS 5	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
3.01	NEW CAP RHC REL COSTS-BLDG & FI									3.01
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS				363	363	363			5
6	ADMINISTRATIVE & GENERAL		294141		45345	339486	37	339523		6
8	OPERATION OF PLANT		5047		9530	14577	8	15967	30552	8
8.01	RHC UTILITY EXPENSE							522		8.01
9	LAUNDRY & LINEN SERVICE				179	179		2040		9
10	HOUSEKEEPING		2769		998	3767	11	7572	229	10
11	DIETARY		11768		10714	22482	10	8048	974	11
12	CAFETERIA		3776			3776		106	313	12
14	NURSING ADMINISTRATION		5639		1844	7483	12	7587	467	14
15	CENTRAL SERVICES & SUPPLY		5488		1865	7353	1	939	454	15
16	PHARMACY		3058		960	4018	9	5230	253	16
17	MEDICAL RECORDS & LIBRARY		41421		12563	53984	15	11304	3430	17
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		79709		30476	110185	58	37723	6601	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		51188		80868	132056	23	21399	4238	37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC		37809		203696	241505	20	32530	3131	41
44	LABORATORY		12020		47241	59261	23	33400	995	44
49	RESPIRATORY THERAPY		4229		7087	11316	8	6576	350	49
50	PHYSICAL THERAPY			17020	41	17061	26	16563		50
53	ELECTROCARDIOLOGY		4229		8395	12624	4	1895	350	53
54	ELECTROENCEPHALOGRAPHY		4216		1715	5931	1	663	349	54
55	MEDICAL SUPPLIES CHARGED TO PAT							8246		55
56	DRUGS CHARGED TO PATIENTS							10326		56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI		32498		597	33095		12901	2691	59
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		34247		10581	44828	21	27225	2836	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC			99903	27751	127654	54	53790		63.50
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES		14915		33101	48016	21	15309	1235	65
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
9	SUBTOTALS		648167	116923	535910	1301000	362	337861	28896	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		3386			3386		95	280	96
98	PHYSICIANS' PRIVATE OFFICES		16614	9206	1613	27433	1	1567	1376	98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		668167	126129	537523	1331819	363	339523	30552	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		8.01	9	10	11	12	14	15	16	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
3.01	NEW CAP RHC REL COSTS-BLDG & FI									3.01
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
8	OPERATION OF PLANT									8
8.01	RHC UTILITY EXPENSE	522								8.01
9	LAUNDRY & LINEN SERVICE		2219							9
10	HOUSEKEEPING			11579						10
11	DIETARY		38	286	31838					11
12	CAFETERIA			92	21288	25575				12
14	NURSING ADMINISTRATION					691	16240			14
15	CENTRAL SERVICES & SUPPLY		47	134		230	214	9372		15
16	PHARMACY			75		461	438	11	10495	16
17	MEDICAL RECORDS & LIBRARY			332		1843				17
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		1096	2078	10550	5992	5556	192		25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		284	1247		1613	1585	2519		37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC		203	921		1843	1648	514		41
44	LABORATORY			293		2304	2032	4300		44
49	RESPIRATORY THERAPY			103		1152	1037	88		49
50	PHYSICAL THERAPY	70	96	513		1843		142		50
53	ELECTROCARDIOLOGY		26	103				3		53
54	ELECTROENCEPHALOGRAPHY			103				1		54
55	MEDICAL SUPPLIES CHARGED TO PAT							1079		55
56	DRUGS CHARGED TO PATIENTS								10495	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI			791						59
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		326	834		1843	1634	276		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	414	56	2547		3226		226		63.50
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES		47	363		2304	2096	21		65
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
91	SUBTOTALS	484	2219	10815	31838	25345	16240	9372	10495	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN			82						96
98	PHYSICIANS' PRIVATE OFFICES	38		682		230				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	522	2219	11579	31838	25575	16240	9372	10495	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		17	25	26	27	
	GENERAL SERVICE COST CENTERS					
3	NEW CAP REL COSTS-BLDG & FIXT					3
3.01	NEW CAP RHC REL COSTS-BLDG & FI					3.01
4	NEW CAP REL COSTS-MVBLE EQUIP					4
5	EMPLOYEE BENEFITS					5
6	ADMINISTRATIVE & GENERAL					6
8	OPERATION OF PLANT					8
8.01	RHC UTILITY EXPENSE					8.01
9	LAUNDRY & LINEN SERVICE					9
10	HOUSEKEEPING					10
11	DIETARY					11
12	CAFETERIA					12
14	NURSING ADMINISTRATION					14
15	CENTRAL SERVICES & SUPPLY					15
16	PHARMACY					16
17	MEDICAL RECORDS & LIBRARY	70908				17
	INPATIENT ROUTINE SERV COST CENTERS					
25	ADULTS & PEDIATRICS	15854	195885	195885		25
	ANCILLARY SERVICE COST CENTERS					
37	OPERATING ROOM	3342	168306	168306		37
40	ANESTHESIOLOGY					40
41	RADIOLOGY-DIAGNOSTIC	30896	313211	313211		41
44	LABORATORY		102608	102608		44
49	RESPIRATORY THERAPY		20630	20630		49
50	PHYSICAL THERAPY		36314	36314		50
53	ELECTROCARDIOLOGY		15005	15005		53
54	ELECTROENCEPHALOGRAPHY		7048	7048		54
55	MEDICAL SUPPLIES CHARGED TO PAT		9325	9325		55
56	DRUGS CHARGED TO PATIENTS		20821	20821		56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI		49478	49478		59
	OUTPATIENT SERVICE COST CENTERS					
61	EMERGENCY	15777	95600	95600		61
62	OBSERVATION BEDS (NON-DISTINCT					62
63.50	RHC		187967	187967		63.50
	OTHER REIMBURSABLE COST CENTERS					
65	AMBULANCE SERVICES		69412	69412		65
71	HOME HEALTH AGENCY					71
	SPECIAL PURPOSE COST CENTERS					
95	SUBTOTALS	65869	1291610	1291610		95
	NONREIMBURSABLE COST CENTERS					
96	GIFT, FLOWER, COFFEE SHOP & CAN		3843	3843		96
98	PHYSICIANS' PRIVATE OFFICES	5039	36366	36366		98
101	CROSS FOOT ADJUSTMENTS					101
102	NEGATIVE COST CENTER					102
103	TOTAL	70908	1331819	1331819		103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET	NEW RHC BUILDING FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		3	3.01	4	5	6A	6	8	
	GENERAL SERVICE COST CENTERS								
3	NEW CAP REL COSTS-BLDG & FIXT	53087							3
3.01	NEW CAP RHC REL COSTS-BLDG &		12413						3.01
4	NEW CAP REL COSTS-MVBLE EQUIP			651485					4
5	EMPLOYEE BENEFITS			440	5813626				5
6	ADMINISTRATIVE & GENERAL	23370		54959	599257	-2008786	12083942		6
8	OPERATION OF PLANT	401		11551	133853		568269	29316	8
8.01	RHC UTILITY EXPENSE						18561		8.01
9	LAUNDRY & LINEN SERVICE			217			72619		9
10	HOUSEKEEPING	220		1210	169561		269505	220	10
11	DIETARY	935		12985	157899		286429	935	11
12	CAFETERIA	300					3776	300	12
14	NURSING ADMINISTRATION	448		2235	189858		270023	448	14
15	CENTRAL SERVICES & SUPPLY	436		2261	21935		33422	436	15
16	PHARMACY	243		1164	137398		186142	243	16
17	MEDICAL RECORDS & LIBRARY	3291		15226	237588		402304	3291	17
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	6333		36937	890804		1342590	6333	25
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	4067		98013	378507		761595	4067	37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC	3004		246882	328237		1157787	3004	41
44	LABORATORY	955		57257	376101		1188738	955	44
49	RESPIRATORY THERAPY	336		8589	123920		234038	336	49
50	PHYSICAL THERAPY		1675	50	418298		589510		50
53	ELECTROCARDIOLOGY	336		10175	59557		67435	336	53
54	ELECTROENCEPHALOGRAPHY	335		2078	19852		23614	335	54
55	MEDICAL SUPPLIES CHARGED TO P						293467		55
56	DRUGS CHARGED TO PATIENTS						367522		56
59	PSYCHIATRIC/PSYCHOLOGICAL SER	2582		723			459148	2582	59
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	2721		12824	341820		968964	2721	61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC		9832	33635	873042		1914482		63.50
	OTHER REIMBURSABLE COST CENTERS								
6	AMBULANCE SERVICES	1185		40119	340533		544851	1185	65
	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
95	SUBTOTALS	51498	11507	649530	5798020	-2008786	12024791	27727	95
	NONREIMBURSABLE COST CENTERS								
96	GIFT, FLOWER, COFFEE SHOP & C	269					3386	269	96
98	PHYSICIANS' PRIVATE OFFICES	1320	906	1955	15606		55765	1320	98
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	668167	126129	537523	1924300		2008786	662736	103
104	UNIT COST MULT-WS B PT I		10.161041		.330998		.166236		104
104	UNIT COST MULT-WS B PT I	12.586264		.825073				22.606631	104
105	COST TO BE ALLOC PER B PT II								105
106	UNIT COST MULT-WS B PT II								106
106	UNIT COST MULT-WS B PT II								106
107	COST TO BE ALLOC PER B PT III				363		339523	30552	107
108	UNIT COST MULT-WS B PT III				.000062		.028097		108
108	UNIT COST MULT-WS B PT III							1.042161	108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	RHC UTILITY EXPENSE SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	
		8.01	9	10	11	12	14	15	16	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
3.01	NEW CAP RHC REL COSTS-BLDG &									3.01
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
8	OPERATION OF PLANT									8
8.01	RHC UTILITY EXPENSE	12413								8.01
9	LAUNDRY & LINEN SERVICE		23672							9
10	HOUSEKEEPING			18159						10
11	DIETARY		402	449	61463					11
12	CAFETERIA			144	41097	111				12
14	NURSING ADMINISTRATION					3	157586			14
15	CENTRAL SERVICES & SUPPLY		503	210		1	2077	774190		15
16	PHARMACY			117		2	4255	938	310889	16
17	MEDICAL RECORDS & LIBRARY			520		8				17
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		11699	3259	20366	26	53903	15866		25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		3026	1955		7	15383	208064		37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC		2161	1444		8	15990	42436		41
44	LABORATORY			459		10	19719	355292		44
49	RESPIRATORY THERAPY			161		5	10062	7237		49
50	PHYSICAL THERAPY	1675	1028	805		8		11755		50
53	ELECTROCARDIOLOGY		273	161				243		53
54	ELECTROENCEPHALOGRAPHY			161				67		54
55	MEDICAL SUPPLIES CHARGED TO P							89115		55
56	DRUGS CHARGED TO PATIENTS								310889	56
59	PSYCHIATRIC/PSYCHOLOGICAL SER			1240						59
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		3478	1308		8	15858	22782		61
62	OBSERVATION BEDS (NON-DISTINC									62
63.50	RHC	9832	601	3998		14		18643		63.50
	OTHER REIMBURSABLE COST CENTERS									
6	AMBULANCE SERVICES		501	569		10	20339	1726		65
	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	11507	23672	16960	61463	110	157586	774164	310889	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & C			129						96
98	PHYSICIANS' PRIVATE OFFICES	906		1070		1		26		98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	COST TO BE ALLOC PER B PT I	21647	84691	319279	364514	257449	331997	61021	238313	103
104	UNIT COST MULT-WS B PT I	1.743898		17.582411		2319.360360		.078819		104
104	UNIT COST MULT-WS B PT I		3.577687		5.930625		2.106767		.766553	104
105	COST TO BE ALLOC PER B PT II									105
106	UNIT COST MULT-WS B PT II									106
106	UNIT COST MULT-WS B PT II									106
107	COST TO BE ALLOC PER B PT III	522	2219	11579	31838	25575	16240	9372	10495	107
108	UNIT COST MULT-WS B PT III	.042053		.637645		230.405405		.012106		108
108	UNIT COST MULT-WS B PT III		.093739		.518003		.103055		.033758	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY TIME SPENT	
		17	
	GENERAL SERVICE COST CENTERS		
3	NEW CAP REL COSTS-BLDG & FIXT		3
3.01	NEW CAP RHC REL COSTS-BLDG &		3.01
4	NEW CAP REL COSTS-MVBLE EQUIP		4
5	EMPLOYEE BENEFITS		5
6	ADMINISTRATIVE & GENERAL		6
8	OPERATION OF PLANT		8
8.01	RHC UTILITY EXPENSE		8.01
9	LAUNDRY & LINEN SERVICE		9
10	HOUSEKEEPING		10
11	DIETARY		11
12	CAFETERIA		12
14	NURSING ADMINISTRATION		14
15	CENTRAL SERVICES & SUPPLY		15
16	PHARMACY		16
17	MEDICAL RECORDS & LIBRARY	8274	17
	INPATIENT ROUTINE SERV COST CENTERS		
25	ADULTS & PEDIATRICS	1850	25
	ANCILLARY SERVICE COST CENTERS		
37	OPERATING ROOM	390	37
40	ANESTHESIOLOGY		40
41	RADIOLOGY-DIAGNOSTIC	3605	41
44	LABORATORY		44
49	RESPIRATORY THERAPY		49
50	PHYSICAL THERAPY		50
53	ELECTROCARDIOLOGY		53
54	ELECTROENCEPHALOGRAPHY		54
55	MEDICAL SUPPLIES CHARGED TO P		55
56	DRUGS CHARGED TO PATIENTS		56
59	PSYCHIATRIC/PSYCHOLOGICAL SER		59
	OUTPATIENT SERVICE COST CENTERS		
61	EMERGENCY	1841	61
62	OBSERVATION BEDS (NON-DISTINC		62
63.50	RHC		63.50
	OTHER REIMBURSABLE COST CENTERS		
65	AMBULANCE SERVICES		65
71	HOME HEALTH AGENCY		71
	SPECIAL PURPOSE COST CENTERS		
95	SUBTOTALS	7686	95
	NONREIMBURSABLE COST CENTERS		
96	GIFT, FLOWER, COFFEE SHOP & C		96
98	PHYSICIANS' PRIVATE OFFICES	588	98
101	CROSS FOOT ADJUSTMENTS		101
102	NEGATIVE COST CENTER		102
103	COST TO BE ALLOC PER B PT I	571277	103
104	UNIT COST MULT-WS B PT I	69.044839	104
104	UNIT COST MULT-WS B PT I		104
105	COST TO BE ALLOC PER B PT II		105
106	UNIT COST MULT-WS B PT II		106
106	UNIT COST MULT-WS B PT II		106
107	COST TO BE ALLOC PER B PT III	70908	107
108	UNIT COST MULT-WS B PT III	8.569978	108
108	UNIT COST MULT-WS B PT III		108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS	2231735					25
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	1117311					37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC	1755777					41
44	LABORATORY	1508749					44
49	RESPIRATORY THERAPY	316736					49
50	PHYSICAL THERAPY	727743					50
53	ELECTROCARDIOLOGY	90068					53
54	ELECTROENCEPHALOGRAPHY	37948					54
55	MEDICAL SUPPLIES CHARGED TO	349276					55
56	DRUGS CHARGED TO PATIENTS	666930					56
59	PSYCHIATRIC/PSYCHOLOGICAL S	615647					59
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	1407867					61
62	OBSERVATION BEDS (NON-DISTI	100238		100238		100238	62
63.50	RHC	2356265					63.50
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES	740190					65
101	SUBTOTAL	14022480		100238		100238	101
102	LESS OBSERVATION BEDS	100238		100238		100238	102
103	TOTAL	13922242					103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT 6	OUTPATIENT 7	TOTAL 8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	2512137		2512137				25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	575063	2274004	2849067	.392167			37
40	ANESTHESIOLOGY							40
41	RADIOLOGY-DIAGNOSTIC	854115	5075797	5929912	.296088			41
44	LABORATORY	1070664	4655834	5726498	.263468			44
49	RESPIRATORY THERAPY	337159	240174	577333	.548619			49
50	PHYSICAL THERAPY	234698	1542462	1777160	.409498			50
53	ELECTROCARDIOLOGY	61738	411098	472836	.190485			53
54	ELECTROENCEPHALOGRAPHY	4764	266296	271060	.139999			54
55	MEDICAL SUPPLIES CHARGED TO	1239164	1053877	2293041	.152320			55
56	DRUGS CHARGED TO PATIENTS	2151862	1081697	3233559	.206253			56
59	PSYCHIATRIC/PSYCHOLOGICAL S		1119353	1119353	.550003			59
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	57091	1572459	1629550	.863961			61
62	OBSERVATION BEDS (NON-DISTI	11200	163220	174420	.574693	.574693	.574693	62
63.50	RHC		1464983	1464983	1.608391			63.50
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES		706460	706460	1.047745			65
101	SUBTOTAL	9109655	21627714	30737369				101
102	LESS OBSERVATION BEDS							102
103	TOTAL			30737369				103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

C[redacted] [ ] TITLE V - O/P [XX] HOSPITAL (14-1351) [ ] SNF
A[redacted]CABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF
BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF
[ ] SUB III [ ] S/B-NF
[ ] SUB IV [ ] ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C, PART II COL. 8	PART I COL. 9	PART II COL. 9	PROGRAM CHARGES - OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC	
		1	1.01	1.02	2	3	4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.392167	.392167	.392167				37
40	ANESTHESIOLOGY							40
41	RADIOLOGY-DIAGNOSTIC	.296088	.296088	.296088				41
44	LABORATORY	.263468	.263468	.263468				44
49	RESPIRATORY THERAPY	.548619	.548619	.548619				49
50	PHYSICAL THERAPY	.409498	.409498	.409498				50
53	ELECTROCARDIOLOGY	.190485	.190485	.190485				53
54	ELECTROENCEPHALOGRAPHY	.139999	.139999	.139999				54
55	MEDICAL SUPPLIES CHARGED TO PAT	.152320	.152320	.152320				55
56	DRUGS CHARGED TO PATIENTS	.206253	.206253	.206253				56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	.550003	.550003	.550003				59
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.863961	.863961	.863961				61
62	OBSERVATION BEDS (NON-DISTINCT	.574693	.574693	.574693				62
63.50	RHC	1.608391	1.608391	1.608391				63.50
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES	1.047745	1.047745	1.047745				65
65.01	AMBULANCE CHARGES (S-2 LINE 56.	1.047745	1.047745					65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.	1.047745	1.047745					65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.	1.047745	1.047745					65.03
101	SUBTOTAL							101
102	CRNA CHARGES							102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104	NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

		1	
	DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.206253	1
[redacted]	VACCINE CHARGES (OTHER THAN HEPATITIS B)		2
[redacted]1	VACCINE CHARGES - HEPATITIS B		2.01
3	VACCINE COSTS (OTHER THAN HEPATITIS B)		3
3.01	VACCINE COSTS - HEPATITIS B		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

C[illegible]	[ ] TITLE V - O/P	[XX] HOSPITAL (14-1351)	[ ] SNF
A[illegible]CABLE	[XX] TITLE XVIII-PT B	[ ] SUB I	[ ] NF
BOXES	[ ] TITLE XIX - O/P	[ ] SUB II	[ ] S/B-SNF
		[ ] SUB III	[ ] S/B-NF
		[ ] SUB IV	[ ] ICF/MR

	COST CENTER DESCRIPTION	PROGRAM CHARGES ALL OTHER (1) (SEE INSTRU.) 5	PPS SERVICES (SEE INSTRU.) 5.01	ALL OTHER (SEE INSTRU.) 5.02	PPS SERVICES (SEE INSTRU.) 5.03	PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST OUTPATIENT AMBULATORY SURGICAL CENTER 6	OUTPATIENT RADIOLOGY 7	OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	928247								37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC	2194602								41
44	LABORATORY	2039083								44
49	RESPIRATORY THERAPY	239790								49
50	PHYSICAL THERAPY	504758								50
53	ELECTROCARDIOLOGY	166034								53
54	ELECTROENCEPHALOGRAPHY	81009								54
55	MEDICAL SUPPLIES CHARGED TO PA	488125								55
56	DRUGS CHARGED TO PATIENTS	415360								56
59	PSYCHIATRIC/PSYCHOLOGICAL SERV	1067546								59
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	597922								61
62	OBSERVATION BEDS (NON-DISTINCT	49569								62
63.50	RHC									63.50
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES									65
65.01	AMBULANCE CHARGES (S-2 LINE 56									65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56									65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56									65.03
101	SUBTOTAL	8772045								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	8772045								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

C[redacted]
A[redacted]CABLE
BOXES

[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1351)
[XX]	TITLE XVIII-PT B	[ ]	SUB I
[ ]	TITLE XIX - O/P	[ ]	SUB II
		[ ]	SUB III
		[ ]	SUB IV

[ ]	SNF		
[ ]	NF		
[ ]	S/B-SNF		
[ ]	S/B-NF		
[ ]	ICF/MR		

	COST CENTER DESCRIPTION	PROGRAM COST ALL OTHER (COLS 1x5) 9	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.01) 9.01	PROGRAM COST ALL OTHER (COLUMNS 1.01x5.02) 9.02	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.03 9.03	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.04 9.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10	HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	364028							37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC	649795							41
44	LABORATORY	537233							44
49	RESPIRATORY THERAPY	131553							49
50	PHYSICAL THERAPY	206697							50
53	ELECTROCARDIOLOGY	31627							53
54	ELECTROENCEPHALOGRAPHY	11341							54
55	MEDICAL SUPPLIES CHARGED TO PAT	74351							55
56	DRUGS CHARGED TO PATIENTS	85669							56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	587154							59
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	516581							61
62	OBSERVATION BEDS (NON-DISTINCT	28487							62
63.50	RHC								63.50
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
65.01	AMBULANCE CHARGES (S-2 LINE 56.								65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.								65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.								65.03
101	SUBTOTAL	3224516							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	3224516							104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS	HOSPITAL (OTHER) (14-1351) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	5477						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	4918						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4918						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	466						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	93						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3443						9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	466						10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	93						11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	SWING-BED ADJUSTMENT	HOSPITAL (OTHER) (14-1351) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF 1	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2231735						21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26	TOTAL SWING-BED COST	227776						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2003959						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2642104						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2642104						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.758471						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	537.23						33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2003959						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	407.47					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1402919					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1402919					41

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1150763					48
49	TOTAL PROGRAM INPATIENT COSTS	2553682					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52	TOTAL PROGRAM EXCLUDABLE COST						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
	TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
	PROGRAM INPATIENT ROUTINE SWING BED COST						
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	189881					60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	37895					61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	227776					62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

		SNF	
		1	
66	SNF/NF/ICF/MR ROUTINE SERVICE COST		66
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68	PROGRAM ROUTINE SERVICE COST		68
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71	CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72	PER DIEM CAPITAL RELATED COSTS		72
73	PROGRAM CAPITAL RELATED COSTS		73
74	INPATIENT ROUTINE SERVICE COST		74
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76	TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78	INPATIENT ROUTINE SERVICE COST LIMITATION		78
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80	PROGRAM INPATIENT ANCILLARY SERVICES		80
81	UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82	TOTAL PROGRAM INPATIENT OPERATING COSTS		82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

	HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	246					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	407.47					84
85 OBSERVATION BED COST	100238					85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V	[XX] HOSPITAL (14-1351)	[ ] SNF	[ ] PPS
[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[ ] TITLE XIX	[ ] SUB II	[ ] S/B-SNF	[XX] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		1805256		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.392167	431643	169276	37
40	ANESTHESIOLOGY				40
41	RADIOLOGY-DIAGNOSTIC	.296088	475283	140726	41
44	LABORATORY	.263468	699639	184332	44
49	RESPIRATORY THERAPY	.548619	302597	166010	49
50	PHYSICAL THERAPY	.409498	160085	65554	50
53	ELECTROCARDIOLOGY	.190485	53050	10105	53
54	ELECTROENCEPHALOGRAPHY	.139999	3306	463	54
55	MEDICAL SUPPLIES CHARGED TO PAT	.152320	1014413	154515	55
56	DRUGS CHARGED TO PATIENTS	.206253	1214520	250498	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	.550003			59
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.863961	9444	8159	61
62	OBSERVATION BEDS (NON-DISTINCT	.574693	1958	1125	62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.608391			63.50
65	AMBULANCE SERVICES				65
101	TOTAL		4365938	1150763	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		4365938		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V	[ ] HOSPITAL	[ ] SNF	[ ] PPS
[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[ ] TITLE XIX	[ ] SUB II	[XX] S/B-SNF (14-Z351)	[XX] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.392167			37
40	ANESTHESIOLOGY				40
41	RADIOLOGY-DIAGNOSTIC	.296088	26578	7869	41
44	LABORATORY	.263468	49953	13161	44
49	RESPIRATORY THERAPY	.548619	34538	18948	49
50	PHYSICAL THERAPY	.409498	52109	21339	50
53	ELECTROCARDIOLOGY	.190485	1392	265	53
54	ELECTROENCEPHALOGRAPHY	.139999			54
55	MEDICAL SUPPLIES CHARGED TO PAT	.152320	114801	17486	55
56	DRUGS CHARGED TO PATIENTS	.206253	165095	34051	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	.550003			59
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.863961	4105	3547	61
62	OBSERVATION BEDS (NON-DISTINCT	.574693			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.608391			63.50
65	AMBULANCE SERVICES				65
101	TOTAL		448571	116666	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		448571		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
	DRG AMOUNT						
1	OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1						1
1.01	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1						1.01
1.02	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS						1.02
1.03	PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1						1.03
1.04	PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1						1.04
1.05	PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1						1.05
1.06	ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07	PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08	SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2	OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01	OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997						2.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT						
3	BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD						3
3.01	NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02	INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03	INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996						3.04
3.05	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06	ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [FOR CR PERIODS ENDING] [ON OR AFTER 7/1/2005] [E-3,PT.VI,LN.15] [PLUS LN.3.06]						3.06
3.07	SUM OF LINES 3.04-3.06	0.00	0.00				3.07
3.08	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS						3.08
3.09	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13	FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS						3.13
3.14	CURRENT YEAR ALLOWABLE FTE						3.14
3.15	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.15
3.16	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.16
		RES. IN INIT YRS					
3.17	SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO	0.00					3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
3.18	CURRENT YEAR RESIDENT TO BED RATIO						3.18
3.19	PRIOR YEAR RESIDENT TO BED RATIO						3.19
3.20	FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19						3.20
3.21	IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1						3.21
3.22	IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1						3.22
3.23	IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES] [PLUS E-3,PT.VI] [3.21-3.23] [LINE 23]						3.23
3.24	SUM OF LINES 3.21-3.23	0				0	3.24
4	DISPROPORTIONATE SHARE ADJUSTMENT PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS						4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS						4.01
4.02	SUM OF 4 AND 4.01						4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE						4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES						4.04
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317						5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302,						5.01
5.02	DIVIDE LINE 5.01 BY LINE 5						5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs						5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK						5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS						5.05
5.06	TOTAL ADDITIONAL PAYMENT						5.06
6	SUBTOTAL						6
7	HOSPITAL SPECIFIC PAYMENTS						7
7.01	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)						7.01
8	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS						8
9	PAYMENT FOR INPATIENT PROGRAM CAPITAL						9
10	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL						10
11	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT						11
11.01	NURSING AND ALLIED HEALTH MANAGED CARE						11.01
11.02	ADD-ON PAYMENT FOR NEW TECHNOLOGIES						11.02
12	NET ORGAN ACQUISITION COST						12
13	COST OF TEACHING PHYSICIANS						13
14	ROUTINE SERVICE OTHER PASS THROUGH COSTS						14
15	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						15
16	TOTAL						16
17	PRIMARY PAYER PAYMENTS						17
18	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES						18
19	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES						19
20	COINSURANCE BILLED TO PROGRAM BENEFICIARIES						20
21	REIMBURSABLE BAD DEBTS						21
21.01	REDUCED PROGRAM REIMBURSABLE BAD DEBTS						21.01
21.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES						21.02
22	SUBTOTAL						22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION						23
24	OTHER ADJUSTMENTS						24
25	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS						25
26	AMOUNT DUE PROVIDER						26
27	SEQUESTRATION ADJUSTMENT						27
28	INTERIM PAYMENTS						28
28.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						28.01
29	BALANCE DUE PROVIDER (PROGRAM)						29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						30
	TO BE COMPLETED BY INTERMEDIARY						
50	OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01						50
51	CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01						51
52	OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIO						52
53	CAPITAL OUTLIER RECONILIATION AMOUNT (SEE INSTRUCTIONS)						53
54	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY						54
55	TIME VALUE OF MONEY (SEE INSTRUCTIONS)						55
56	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)						56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1351) 1	HOSPITAL (14-1351) 1.01	HOSPITAL (14-1351) 1.02	
1	MEDICAL AND OTHER SERVICES	3224516			1
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03	1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04	LINE 1.01 TIMES LINE 1.03				1.04
1.05	LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06	TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07	AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2	INTERNS AND RESIDENTS				2
3	ORGAN ACQUISITIONS				3
4	COST OF TEACHING PHYSICIANS				4
5	TOTAL COST	3224516			5
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6	ANCILLARY SERVICE CHARGES				6
7	INTERNS AND RESIDENTS SERVICE CHARGES				7
8	ORGAN ACQUISITION CHARGES				8
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10	TOTAL REASONABLE CHARGES				10
	CUSTOMARY CHARGES				
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13	RATIO OF LINE 11 TO LINE 12				13
14	TOTAL CUSTOMARY CHARGES				14
15	EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17	LESSER OF COST OR CHARGES	3256761			17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1351) 1	HOSPITAL (14-1351) 1.01	HOSPITAL (14-1351) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES	67377			18
18.01	COINSURANCE	1344460			18.01
19	SUBTOTAL	1844924			19
20	SUM OF AMOUNTS FROM WKST E, PARTS C,D & E				20
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				21
22	ESRD DIRECT MEDICAL EDUCATION COSTS				22
23	SUBTOTAL	1844924			23
24	PRIMARY PAYER PAYMENTS	582			24
25	SUBTOTAL	1844342			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	309487			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	309487			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	309487			27.02
28	SUBTOTAL	2153829			28
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				29
30	OTHER ADJUSTMENTS				30
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)				30.99
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				31
32	SUBTOTAL	2153829			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	1940185			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	213644			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		HOSPITAL (14-1351) OCTOBER 1, 1997 PRIOR TO ON OR AFTER 1 1.01	
1	STANDARD OVERHEAD AMOUNTS (ASC FEES)		1
2	DEDUCTIBLES		2
3	SUBTOTAL		3
4	80 PERCENT OF LINE 3		4
5	ASC PORTION OF BLEND		5
6	OUTPATIENT ASC COST		6
	COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES		7
	CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)		9
10	RATIO OF LINE 8 TO LINE 9		10
11	TOTAL CUSTOMARY CHARGES		11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		13
14	LESSER OF COST OR CHARGES		14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE		15
16	TOTAL		16
17	HOSPITAL SPECIFIC PORTION OF BLEND		17
18	ASC BLENDED AMOUNT		18
19	LESSER OF LINES 16 OR 18		19
20	PART B DEDUCTIBLES AND COINSURANCE		20
21	ASC PAYMENT AMOUNT		21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		HOSPITAL (14-1351) OCTOBER 1, 1997 PRIOR TO 1	HOSPITAL (14-1351) OCTOBER 1, 1997 ON OR AFTER 1.01	
1	PREVAILING CHARGES			1
2	62 PERCENT OF LINE 1			2
3	DEDUCTIBLES			3
4	SUBTOTAL			4
5	BLENDED CHARGE PROPORTION			5
6	COST OF OUTPATIENT RADIOLOGY			6
	COMPUTATION OF LESSER OF COST OR CHARGES			
7	TOTAL CHARGES			7
	CUSTOMARY CHARGES			
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)			9
10	RATIO OF LINE 8 TO LINE 9			10
11	TOTAL CUSTOMARY CHARGES			11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			13
14	LESSER OF COST OR CHARGES			14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
15	DEDUCTIBLES AND COINSURANCE			15
16	TOTAL			16
17	COST PROPORTION			17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT			18
19	LESSER OF LINE 16 OR LINE 18			19
20	PART B DEDUCTIBLES AND COINSURANCE			20
21	RADIOLOGY PAYMENT AMOUNT			21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		HOSPITAL (14-1351) OCTOBER 1, 1997 PRIOR TO 1	ON OR AFTER 1.01	
1	PREVAILING CHARGES			1
2	42 PERCENT OF LINE 1			2
3	DEDUCTIBLES			3
4	SUBTOTAL			4
5	BLENDED CHARGE PROPORTION			5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES			6
	COMPUTATION OF LESSER OF COST OR CHARGES			
7	TOTAL CHARGES			7
	CUSTOMARY CHARGES			
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)			9
10	RATIO OF LINE 8 TO LINE 9			10
11	TOTAL CUSTOMARY CHARGES			11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			13
14	LESSER OF COST OR CHARGES			14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
15	DEDUCTIBLES AND COINSURANCE			15
16	TOTAL			16
17	COST PROPORTION			17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT			18
19	LESSER OF LINE 16 OR LINE 18			19
20	PART B DEDUCTIBLES AND COINSURANCE			20
21	DIAGNOSTIC PAYMENT AMOUNT			21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1

HOSPITAL (14-1351)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1799205		1802185	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01			09/21/2007	138000	3.01
	PROGRAM	.02					3.02
	TO	.03		NONE			3.03
	PROVIDER	.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER	.51					3.51
	TO	.52		NONE		NONE	3.52
	PROGRAM	.53					3.53
		.54					3.54
SUBTOTAL		.99				138000	3.99
4 TOTAL INTERIM PAYMENTS				1799205		1940185	4
TO BE COMPLETED BY INTERMEDIARY							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01					5.01
	TO	.02					5.02
	PROVIDER	.03					5.03
	PROVIDER	.50					5.50
	TO	.51					5.51
	PROGRAM	.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____ DATE (MO/DAY/YR): _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1

SWING BED SKILLED NURSING FACILITY (14-Z351)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				325964			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
	PROGRAM	.02					3.02
	TO	.03		NONE		NONE	3.03
	PROVIDER	.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER	.51					3.51
	TO	.52		NONE		NONE	3.52
	PROGRAM	.53					3.53
		.54					3.54
SUBTOTAL		.99					3.99
4 TOTAL INTERIM PAYMENTS				325964			4
TO BE COMPLETED BY INTERMEDIARY							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01					5.01
	TO	.02					5.02
	PROVIDER	.03					5.03
	PROVIDER	.50					5.50
	TO	.51					5.51
	PROGRAM	.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____ DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

SUPPLEMENTAL
WORKSHEET E-2

CALCULATION OF NET COST OF COVERED SERVICES

		TITLE V S/B NF	--- TITLE XVIII --- S/B SNF PART A (14-Z351)	S/B SNF PART B	--- TITLE XIX --- S/B SNF (14-Z351)	S/B NF	
		1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		230054				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		117833				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		559				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		347887				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		347887				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		347887				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		15478				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		332409				15
16	OTHER ADJUSTMENTS						16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)						17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES						17.01
18	TOTAL		332409				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		325964				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		6445				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF I	
1	INPATIENT SERVICES	2553682						1
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)							1.01
2	ORGAN ACQUISITION							2
3	COST OF TEACHING PHYSICIANS							3
4	SUBTOTAL	2553682						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	2579219						6
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES							
7	ROUTINE SERVICE CHARGES							7
8	ANCILLARY SERVICE CHARGES							8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE							9
10	TEACHING PHYSICIANS							10
11	TOTAL REASONABLE CHARGES							11
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS							12
13	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							13
14	RATIO OF LINE 12 TO LINE 13							14
15	TOTAL CUSTOMARY CHARGES							15
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							16
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF I	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							18
19	COST OF COVERED SERVICES	2579219						19
20	DEDUCTIBLES	520555						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	2058664						22
23	COINSURANCE	1184						23
24	SUBTOTAL	2057480						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	57625						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	57625						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							25.02
26	SUBTOTAL	2115105						26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION							27
28	OTHER ADJUSTMENTS							28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS							29
30	SUBTOTAL	2115105						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	1799205						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	315900						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2							34

BALANCE SHEET

WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2237253				1
2	TEMPORARY INVESTMENTS	6079383				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	2401420				4
5	OTHER RECEIVABLES	978291				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	137350				7
8	PREPAID EXPENSES	164233				8
9	OTHER CURRENT ASSETS	62411				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	12060341				11
	FIXED ASSETS					
12	LAND	132111				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS	226853				13
13.01	ACCUMULATED DEPRECIATION	-168918				13.01
14	BUILDINGS	11584839				14
14.01	ACCUMULATED DEPRECIATION	-4480476				14.01
15	LEASEHOLD IMPROVEMENTS					15
15.01	ACCUMULATED AMORTIZATION					15.01
16	FIXED EQUIPMENT	5537216				16
16.01	ACCUMULATED DEPRECIATION	-3735222				16.01
17	AUTOMOBILES AND TRUCKS					17
17.01	ACCUMULATED DEPRECIATION					17.01
18	MAJOR MOVABLE EQUIPMENT					18
18.01	ACCUMULATED DEPRECIATION					18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	9096403				21
	OTHER ASSETS					
22	INVESTMENTS					22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	2373390				25
26	TOTAL OTHER ASSETS	2373390				26
27	TOTAL ASSETS	23530134				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	398049				28
29	SALARIES, WAGES & FEES PAYABLE	568061				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)					31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	196070				35
36	TOTAL CURRENT LIABILITIES	1162180				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE	6417887				38
39	UNSECURED LOANS					39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66					40
41	OTHER LONG TERM LIABILITIES					41
42	TOTAL LONG TERM LIABILITIES	6417887				42
43	TOTAL LIABILITIES	7580067				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	15950067				44
45	SPECIFIC PURPOSE FUND BALANCE					45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL					48
49	PLANT FUND BALANCE - INVESTED IN PLANT					49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					50
51	TOTAL FUND BALANCES	15950067				51
52	TOTAL LIABILITIES AND FUND BALANCES	23530134				52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
1	FUND BALANCES AT BEGINNING OF PERIOD	15378349				1
2	NET INCOME (LOSS)	571718				2
3	TOTAL	15950067				3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS					10
11	SUBTOTAL	15950067				11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	15950067				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	2642104		2642104	1
2	SUBPROVIDER I				2
4	SWING BED - SNF				4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY				6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	2642104		2642104	9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	INTENSIVE CARE UNIT				10
11	CORONARY CARE UNIT				11
12	BURN INTENSIVE CARE UNIT				12
13	SURGICAL INTENSIVE CARE UNIT				13
14	OTHER SPECIAL CARE (SPECIFY)				14
15	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16	TOTAL INPATIENT ROUTINE CARE SERVICES	2642104		2642104	16
17	ANCILLARY SERVICES	6847327		6847327	17
18	OUTPATIENT SERVICES		21416202	21416202	18
18.50	RHC		1763834	1763834	18.50
19	HOME HEALTH AGENCY				19
20	AMBULANCE		706460	706460	20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24					24
25	TOTAL PATIENT REVENUES	9489431	23886496	33375927	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		15648997	26
27	PROVISION FOR UNCOLLECTIBLE ACCOUNT	1330384		27
28				28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS		1330384	33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		16979381	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	33375927	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	16918618	2
3	NET PATIENT REVENUES	16457309	3
4	LESS - TOTAL OPERATING EXPENSES	16979381	4
5	NET INCOME FROM SERVICE TO PATIENTS	-522072	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	155759	6
7	INCOME FROM INVESTMENTS	518713	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	76785	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	3252	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	TAX REVENUE	224475	24
24.01	RENTAL INCOME	45389	24.01
24.02	MISCELLANEOUS INCOME	69417	24.02
25	TOTAL OTHER INCOME	1093790	25
26	TOTAL	571718	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	571718	31

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	4A	25	26	27	
	GENERAL SERVICE COST CENTERS						
3	NEW CAP REL COSTS-BLDG & FIXT						3
3.01	NEW CAP RHC REL COSTS-BLDG & FI						3.01
4	NEW CAP REL COSTS-MVBLE EQUIP						4
5	EMPLOYEE BENEFITS						5
6	ADMINISTRATIVE & GENERAL						6
8	OPERATION OF PLANT						8
8.01	RHC UTILITY EXPENSE						8.01
9	LAUNDRY & LINEN SERVICE						9
10	HOUSEKEEPING						10
11	DIETARY						11
12	CAFETERIA						12
14	NURSING ADMINISTRATION						14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY						17
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS						25
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
53	ELECTROCARDIOLOGY						53
54	ELECTROENCEPHALOGRAPHY						54
55	MEDICAL SUPPLIES CHARGED TO PAT						55
56	DRUGS CHARGED TO PATIENTS						56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI						59
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RHC						63.50
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES						65
71	HOME HEALTH AGENCY						71
	SPECIAL PURPOSE COST CENTERS						
95	SUBTOTALS						95
	NONREIMBURSABLE COST CENTERS						
96	GIFT, FLOWER, COFFEE SHOP & CAN						96
98	PHYSICIANS' PRIVATE OFFICES						98
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL						103
104	TOTAL STATISTICAL BASIS						104
105	UNIT COST MULTIPLIER						105
105	UNIT COST MULTIPLIER						105

RHC I

WORKSHEET M-1

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT NO: 14-3458

APPLICABLE BOX: [XX] RHC
[ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	293477		293477		293477	-28510	264967	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	196210		196210		196210		196210	3
4	VISITING NURSE								4
5	OTHER NURSE	168385		168385		168385		168385	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	3058		3058		3058		3058	9
10	SUBTOTAL (SUM OF LINES 1-9)	661130		661130		661130	-28510	632620	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT		434594	434594		434594		434594	11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (SUM OF LINES 11-13)		434594	434594		434594		434594	14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		22397	22397		22397		22397	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		106084	106084		106084		106084	18
19	OTHER HEALTH CARE COSTS		61735	61735		61735		61735	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		190216	190216		190216		190216	21
22	TOTAL COSTS OF HEALTH CARE SERVICES	661130	624810	1285940		1285940	-28510	1257430	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS								28
	FACILITY OVERHEAD								
29	FACILITY COSTS	240423		240423		240423		240423	29
30	ADMINISTRATIVE COSTS								30
31	TOTAL FACILITY OVERHEAD	240423		240423		240423		240423	31
32	TOTAL FACILITY COSTS	901553	624810	1526363		1526363	-28510	1497853	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
COMPONENT NO: 14-3458

WORKSHEET M-2

C [XX] RHC
A CABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	1.51	5421	4200	6342		1
2	PHYSICIAN ASSISTANTS			2100			2
3	NURSE PRACTITIONERS	2.48	9372	2100	5208		3
4	SUBTOTAL	3.99	14793		11550	14793	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS	3.99	14793			14793	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		5055			5055	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	1257430	10
11	TOTAL NONREIMBURSABLE COSTS		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	1257430	12
13	RATIO OF RHC/FQHC SERVICES	1.000000	13
14	TOTAL FACILITY OVERHEAD	240423	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	858412	15
16	TOTAL OVERHEAD	1098835	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	1098835	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	1098835	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	2356265	20

RHC I

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT NO: 14-3458

C[redacted] [XX] RHC [ ] TITLE V
AP[redacted]CABLE BOX: [ ] FQHC [XX] TITLE XVIII
[ ] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	2356265	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	6501	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	2349764	3
4	TOTAL VISITS	14793	4
5	PHYSICIANS VISITS UNDER AGREEMENT	5055	5
6	TOTAL ADJUSTED VISITS	19848	6
7	ADJUSTED COST PER VISIT	118.39	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT	100.88	100.88		8
9	RATE FOR PROGRAM COVERED VISITS	118.39	118.39		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	5395		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	638714		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES			14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST			15
16	TOTAL PROGRAM COST		638714	16
16.01	PRIMARY PAYOR PAYMENTS		275	16.01
17	LESS: BENEFICIARY DEDUCTIBLE		56491	17
18	NET PROGRAM COST EXCLUDING VACCINES		581948	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE		465558	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION		6501	20
21	TOTAL REIMBURSABLE PROGRAM COST		472059	21
22	REIMBURSABLE BAD DEBTS		2616	22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT		474675	24
25	INTERIM PAYMENTS		365758	25
2[redacted]	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
2[redacted]	BALANCE DUE COMPONENT/PROGRAM		108917	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			27

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC I

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT NO: 14-3458

C[illegible] [XX] RHC [ ] TITLE V
APPLICABLE BOX: [ ] FQHC [XX] TITLE XVIII
[ ] TITLE XIX

		PNEUMOCOCCAL 1	INFLUENZA 2	
1	HEALTH CARE STAFF COSTS	632620	632620	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000062	0.000872	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	39	552	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	392	2486	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	431	3038	5
6	TOTAL DIRECT COST OF THE FACILITY	1257430	1257430	6
7	TOTAL OVERHEAD	1098835	1098835	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.000343	0.002416	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	377	2655	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	808	5693	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	8	113	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	101.00	50.38	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	8	113	13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	808	5693	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		6501	15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		6501	16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER
FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC I
COMPONENT NO: 14-3458

WORKSHEET M-5

C[illegible] [XX] RHC
A[illegible]CABLE BOX: [ ] FQHC

DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				365758	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01			3.01
	PROGRAM	.02			3.02
	TO	.03		NONE	3.03
	PROVIDER	.04			3.04
		.05			3.05
		.50			3.50
	PROVIDER	.51			3.51
	TO	.52		NONE	3.52
	PROGRAM	.53			3.53
		.54			3.54
SUBTOTAL		.99			3.99
4 TOTAL INTERIM PAYMENTS				365758	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
	TO	.02			5.02
	PROVIDER	.03			5.03
	PROVIDER	.50			5.50
	TO	.51			5.51
	PROGRAM	.52			5.52
SUBTOTAL		.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01			6.01
	PROVIDER TO PROGRAM	.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY					7

N[illegible]OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES			CLINIC NAME: CLAY COUNTY HOSPITAL		REPORTING PERIOD FROM: 1-Mar-07 TO: 29-Feb-08		ATTACHMENT #1
	COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	TOTAL COL.1&2 3	RECLASSI-FICATIONS 4	RECLASSIFIED TRIAL BALANCE COL.3&4 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES COL.5&6 7
1	SUPPLEMENTAL COSTS			0		0		0
2	Pharmacy			0		0		0
3	Patient Transportation			0		0		0
4	Medical Case Management(see instructions)			0		0		0
5	Health Education			0		0		0
6	Nutrition Counseling			0		0		0
7	Others(specify)			0		0		0
8				0		0		0
9				0		0		0
10				0		0		0
11				0		0		0
12	Supplemental Subtotal(sum of lines 2 through 11)	0	0	0	0	0	0	0
13	DENTAL(see schedule J)			0		0		0
14	NON-ALLOWABLE COST CENTERS							
15	HM\HK Case Management			0		0		0
16	WIC(Women,Infants, & Children)			0		0		0
17	Fundraising & Public Relations			0		0		0
18	Social Services			0		0		0
19	Unlicensed Social Workers			0		0		0
20	Others(specify)			0		0		0
21				0		0		0
22				0		0		0
23				0		0		0
24				0		0		0
25	Non-Allowable Subtotal(sum of lines 15 - 24)	0	0	0	0	0	0	0
26	Totals for schedule C (sum of lines 12,13, &25)	0	0	0	0	0	0	0

N/A

NOTE: The total cost on line 26 , column 7, must agree with schedule A, line 46, column 7.

NOTE: This schedule allows for supplemental reimbursement of some costs which are not allowable under the Medicare program.

RURAL HEALTH CLINIC DENTAL STATISTICS		CLINIC NAME **CLAY COUNTY HOSPITAL**			REPORTING PERIOD FROM: **1-Mar-07** TO: **29-Feb-08**			ATTACHMENT #2
	COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	COL.1&2 3	RECLASSI-FICATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3&4) 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES (COL.5&6) 7
1	FQHC DENTAL STAFF COST			0		0		0
2	Dentists			0		0		0
3	Dental Hygienist			0		0		0
4				0		0		0
5				0		0		0
6	TOTAL - Dentists(Sum of lines 1 through 5)	0	0	0	0	0	0	0
7	Other - Dental Staff			0		0		0
8				0		0		0
9				0		0		0
10				0		0		0
11	SUBTOTAL- Other Dental Staff(Sum of lines 7-10)	0	0	0	0	0	0	0
12	TOTAL - Dental Staff (Sum of lines 6 and 11)	0	0	0	0	0	0	0
13	Dental Services Under Agreement			0		0		0
14				0		0		0
15	TOTAL DENTAL COST(Sum of lines 12 through 14)	0	0	0	0	0	0	0

N/A

DENTAL SERVICES PERSONNEL,EQUIVALENTS,HOURS ON SITE, AND ENCOUNTERS

DENTAL SERVICES PERSONNEL		FULL TIME PERSONNEL EQUIVALENTS (FTEs) 1	HEALTH SERVICES HOURS ON-SITE 2	ENCOUNTERS ON-SITE 3	ENCOUNTERS OFF-SITE 4	ENCOUNTERS TOTAL 5
16	FQHC DENTAL STAFF					0
17	Dentists					0
18	Dental Hygienist					0
19						0
20						0
21	TOTAL - Dentists(Sum of lines 17 through 20)	0.00	0.00	0	0	0
22	Other - Dental Staff					0
23						0
24						0
25						0
26	SUBTOTAL-Other Dental Staff(Sum of lines 22 through 25)	0.00	0.00	0	0	0
27	TOTAL - Dental Staff(Sum of lines 21 and 26)	0.00	0.00	0	0	0
28	Dental Services Under Agreement					0
29						0
30	TOTAL DENTAL(Sum of lines 27 through 29)	0.00	0.00	0	0	0

NOTE: Total dental cost from line 15, column 7, must agree with schedule C, line 13.